



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

PARK PLAZA HOSPITAL  
c/o LAW OFFICES OF P. MATTHEW O'NEIL  
816 CONGRESS AVENUE SUITE 1600  
AUSTIN TX 78701

#### **Respondent Name**

LIBERTY INSURANCE CORP

#### **Carrier's Austin Representative Box**

Box Number 01

#### **MFDR Tracking Number**

M4-08-4685-02

#### **MFDR Date Received**

MARCH 21, 2008

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary Dated March 21, 2008:** "The patient was admitted on 3/21/07 for acute rehab due to difficult ambulating post surgery...the carrier denied the services alleging that the same were not authorized. However, the services were authorized directly with the patient's employer. As set forth in the business records of the hospital, the hospital was unaware of the specific carrier at admission. Thus, the hospital directly contacted the patient employer. As noted on the hospital's records included herein, on 3/20/07 the hospital directly contacted Ron Bisep with the patient's employer. He represented to be the employer's safety director and he verbally authorized and approved the admission...The services were authorized and medically necessary. Pursuant to DWC Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40,000, the entire bill will be paid using the stop-loss reimbursement factor of 75% of usual and customary charges."

**Requestor's Position Summary Dated May 9, 2008:** "First, and as previously raised, my client directly contacted the risk manager for the patient's employer, who expressly authorized the services...Also, as described in the attached discharge summary, the treating physician evaluated the patient on 3/19/07 and he was transferred to rehab on 3/21/07. AS further noted in the discharge summary, he was discussed by the rehab team in the presence of the Workers Compensation case manager. Further, and as set forth in the attached hospital collection notes on the date of 3/27/07, the hospital spoke with a Brenda Krawczyk. It is believed that Ms. Krawczyk is a representative of Liberty Mutual and may be the case worker for this admission, although I am not certain of this. This note also provides that the hospital received authorization and approval for the rehabilitation. On information and belief, it was also at this time that Ms. Krawczyk provided the hospital with the claim billing information for Liberty Mutual...In the response to my client's MDR, Liberty Mutual argues that pursuant to preauthorization rules, the carrier had 5 working days to request reconsideration once the original denial for preauthorization was received...the carrier's interpretation of the rule is misplaced. Subsection (o) of Rule 134.600 only provides that if an initial response is a denial of preauthorization, the requestor may request reconsideration. This is not mandatory under rule."

**Amount in Dispute:** \$60,568.68

## **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary dated April 7, 2008 and November 29, 2011:** "The provider failed to seek pre-authorization from the carrier as mandated by the Texas Workers Compensation Act §413.014 and §408.0042."

**Response Submitted by:** Liberty Mutual Insurance Group

**Respondent's Position Summary dated February 1, 2012:** "Because the Provider failed to acquire the necessary pre-authorization for admission and treatment, Carrier reimbursed nothing...Further, were the admission properly preauthorized, the Requestor would not qualify for payment under the Stop-Loss Exception. It has not met its burden of demonstrating unusually extensive services, and the documentation adduced thus far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception. No monies are due to the Requestor."

**Response Submitted by:** Hanna & Plaut, L.L.P.

## **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2007 through April 6, 2007	Inpatient Hospital Rehabilitation Services	\$60,568.68	\$0.00

## **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
  - X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
  - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
  - We are unable to process payment from a balance due statement. If balance due is from a previous payment, please submit a copy of the EOP with written request for review. If this is initial submission, please submit itemized charges on an appropriate billing form (HCFA-1500/UB92).

### **Issues**

1. Does the submitted documentation support that preauthorization was obtained in accordance with 28 Texas Administrative Code §134.600?
2. Did the requestor support position that the disputed services qualify for reimbursement under the stop-loss provisions of 28 Texas Administrative Code §134.401?
3. Did the requestor's documentation support amount sought for the disputed services was fair and reasonable?

## Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization, and X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600."

The requestor states in the position summary that preauthorization was obtained from the patient's employer. 28 Texas Administrative Code §134.600(f) states "The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section."

The requestor did not support position that preauthorization was obtained in accordance with 28 Texas Administrative Code §134.600(f) prior to providing the rehabilitation services; therefore, reimbursement can not be recommended.

2. The requestor states in the position summary that "The patient was admitted on 3/21/07 for acute rehab due to difficult ambulating post surgery".

The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "Pursuant to DWC Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40,000, the entire bill will be paid using the stop-loss reimbursement factor of 75% of usual and customary charges."

28 Texas Administrative Code §134.401(a)(2) states that "rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate; therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.

3. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "Pursuant to DWC Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40,000, the entire bill will be paid using the stop-loss reimbursement factor of 75% of usual and customary charges."
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The requestor does not discuss or explain how payment of \$60,568.68 would result in a fair and reasonable reimbursement.
- The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(a)(2).
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This

methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the disputed services were preauthorized in accordance with Division rules at 28 Texas Administrative Code §134.600. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that the amount sought is fair and reasonable in accordance with Division rules at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

_____	_____	1/8/2013
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	1/8/2013
Signature	Medical Fee Dispute Resolution Manager	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**